CHIROPRACTIC INSURANCE QUALIFICATION WORKSHEET

Please contact your insurance carrier and fill out this form COMPLETELY. Return it to us **on your next visit for our review.**

- We are an out of network provider with insurance. We can accept your insurance if you have out of network benefits.
- It is important that you understand that health and accident insurance policies are an arrangement *between you and your insurance company*. Therefore, *you are personally responsible for all service charges incurred in our office.*
- We expect payment in full when services are rendered until your insurance coverage has been verified.
- We do NOT accept secondary insurance.

PATIENT'S NAME_____ DOB_____

ADDRESS_____ PHONE#_____

SUBSCRIBER'S NAME (IF NOT PATIENT, this could be husband/wife/parent, etc)_____

SUBSCRIBER DATE OF BIRTH_____ SUBSCRIBER SSN_____

INSURANCE CO._____ ADDRESS_____

POLICY #_____ GROUP#_____ PLAN_____

Person you spoke with _____Date_____

Does my policy cover **OUT OF NETWORK CHIROPRACTIC?**_____

What is my **deductible**?_____ Is that yearly?_____ **Has it been met? How much?**_____

What is the effective date of my policy?_____ Is there a fourth quarter carryover?_____

What is my co-payment?_____ How many visits allowed annually?_____

Are there any limits to my coverage?_____ What?_____

Reference Number_____

Have you seen another chiropractor this year?_____ How many visits?_____

By signing below, I certify all information is true and correct to the best of my knowledge.

Patient Signature:_____ Date:_____